

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/2012  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445136 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____   |  | (X3) DATE SURVEY<br>COMPLETED<br><br>07/12/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED NURSING AND REHABILITATION-MASTERS |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>278 DRY VALLEY RD<br>ALGOOD, TN 38501   |  |   |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                      |
| F 000  | <p><b>INITIAL COMMENTS</b></p> <p>On July 9-12, 2012, an annual recertification survey was completed.</p> <p>The facility was cited with an Immediate Jeopardy at F223 and F226 with a scope and severity of "J" for failing to protect one resident (#11) being transported by emergency personnel from the facility to the emergency room from abuse. The facility's failure to intervene when abuse was observed was likely to cause serious injury, harm, impairment, or death to resident #11, and potentially for any resident who is abused.</p> <p>An extended survey was completed on July 12, 2012.</p> <p>The Administrator and the Director of Nursing (DON) were informed of the Immediate Jeopardy on July 11, 2012, at 2:15 p.m., in the Administrator's Office.</p> <p>The Immediate Jeopardy was effective July 10, 2012, through July 11, 2012. Substandard Quality of Care was cited under F223-J and F226-J. An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions validated on-site by the survey team on July 12, 2012.</p> <p>Non-compliance of the Immediate Jeopardy tags continue at a scope and severity of a "D" level for monitoring of corrective actions through the facility's Quality Assurance/Performance Improvement Program.</p> <p>The facility is required to submit a plan of correction for all citations.</p> | F 000   |  |  |   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Sylvia J. Burt* RN, NHA

Executive Director 7/30/12

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 159<br>SS=D  | <p>4B3.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the</p> | F 159   | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F159<br/>It is the practice of this facility to notify each resident that receives Medicaid benefits when the amount in the residents account reaches \$200 less than the SSI resource limit for one person as specified in the ACT. The facility will continue to follow facility policy of sending the Medicaid Resident Fund Notification letter to the responsible parties and/or to the resident to inform them that the resident is within 200.00 of the Medicaid limit of 2000.00. We notified the responsible parties with the letter on resident #201, #78, #208, #155, #126 on 7/3/12 and a copy of the letter is on file in each resident's financial file.</p> <p>All resident trust fund accounts were audited on 7/26/12 by Business Office Manager as of this time are below the Medicaid limit. The Business Office Manager or designee will continue to monitor accounts monthly for residents are approaching within the \$200 Medicaid limit and will notify the resident and/or responsible party and DHS case worker as well.</p> <p>The facility administrator will perform spot audits on the resident trust fund monthly X 3 months and then quarterly, thereafter, and report findings to the facility Performance Improvement Committee (Director of Nursing, Assist Director of Nursing, Executive Director, Case Manager, Business Office Manager, Admissions Coordinator, Maintenance Supervisor, Account Manager, Infection Control Nurse, Dietician, Medical Director, Activities, and MDS Coordinator) at its regular monthly meeting for</p> | 8/3/2012                   |   |

Sylvia J. Burtin RN, NHA

7/30/12

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| F 159  | <p>Continued From page 2</p> <p>resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on review of the Resident Fund Management Service and interview the facility failed to notify residents and/or responsible parties of balances within two hundred dollars receiving Social security Income (SSI) resource amount for five residents (#201, #78, #208, #155, #126) of seventy-seven resident balances reviewed.</p> <p>The findings included:</p> <p>Review of the Resident Fund Management Service dated July 12, 2012, revealed five residents with account balances of Resident #201 \$2,296.75, Resident #78 \$2,264.94, Resident #208 \$2,298.03, Resident #155 \$2,571.30, and Resident #126 \$3,868.29.</p> <p>Interview with the Business Office Manager on July 12, at 3:30 p.m., in the front office, confirmed five residents who received Medicaid benefits accounts had reached over the SSI resource limit. Continued interview at this time revealed no documentation the facility had notified residents or representatives of the SSI resource limit when the amount in the resident's account reached \$200 less than the SSI resource limit for one</p> | F 159   | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>review, discussion and recommendations, if indicated.</p> |                            |   |

*Sepina J. Burton RN, NHA*

*7/30/12*

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| F 159<br>F 164<br>SS=D   | <p>Continued From page 3 person.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on medical record review, observation, and interview, the facility failed to promote care that maintained or enhanced dignity during insulin</p> | F 159<br>F 164   | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F 164<br/>It is the practice of this facility that resident has the right to personal privacy and confidentiality of his or her personal and clinical records.<br/>Nurse # 3 failed to provide privacy during finger stick blood sugar checks as well as insulin injection. Nurse # 3 did provide privacy to residents in their rooms but did not pull the curtain. Nurse # 3 has been counseled by the DNS on facility policy on privacy on 7/19/12 @ 11:30am. Nurse # 3 verbalized to DNS understanding of policy.<br/>All licensed nurses will be in-serviced on the facility policy on personal privacy by 7/26/12 by the DNS/SDC/nurse managers. Meeting scheduled for 7/19/12, 7/20/12, 7/21/12, 7/22/12, 7/23/12, 7/24/12 and 7/25/12.<br/>DNS/ADNS/nurse managers will make rounds 3-5 times a week to monitor at least 2 nurses per shift for privacy during medication administration treatments to include finger stick blood sugar checks and insulin injections. These rounds by DNS/ADNS/ SDC and/or RN supervisors will continue weekly X 4 weeks or until substantial compliance achieved and then monthly X one quarter and then at least quarterly thereafter. The SDC will monitor and address privacy issues related to medication</p> | 8/3/2012             |  |

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| F 164  | Continued From page 4<br>injections for two residents (#90, #193) of forty<br>residents reviewed.<br><br>The findings included:<br><br>Resident #90 was admitted to the facility on<br>August 12, 2011, and readmitted on February 7,<br>2012, with diagnoses of Dementia with Behavior<br>Disorder, Alzheimer's Dementia, and Diabetes.<br><br>Observation in the resident's room on July 10,<br>2012, at 11:49 a.m., revealed Licensed Practical<br>Nurse (LPN) #3 performed a finger stick and<br>administered an insulin injection in the resident's<br>abdomen, with the resident lying on the bed,<br>visible to the roommate, without pulling the<br>privacy curtain.<br><br>Resident #193 was admitted to the facility on July<br>2, 2010, with diagnoses of Alzheimer's Disease,<br>Cirrhosis, and Diabetes.<br><br>Observation in the resident's room on July 10,<br>2012, at 12:00 p.m., revealed LPN #3 performed<br>a finger stick and administered an insulin injection<br>in the left arm, with the resident sitting on the bed,<br>visible to the roommate, without pulling the<br>privacy curtain.<br><br>Interview with LPN #3 in the hallway on July 10,<br>2012, at 12:05 p.m., confirmed the facility failed to<br>maintain privacy during two finger sticks and two<br>insulin injections for two residents. | F 164   | This Plan of Correction is the center's credible<br>allegation of compliance.<br><br>Preparation and/or execution of this plan of correction<br>does not constitute admission or agreement by the<br>provider of the truth of the facts alleged or conclusions<br>set forth in the statement of deficiencies. The plan of<br>correction is prepared and/or executed solely because<br>it is required by the provisions of federal and state law.<br><br>administration and treatment competencies on<br>hire during licensed nurse orientation, as well as<br>annually. Pharmacy consult will assist by auditing<br>at least one licensed nurse medication pass per<br>quarter and include in his report any<br>concerns/issues with privacy during medication<br>administration pass to the DNS.<br>The results of the audits and the pharmacy<br>reports on medication administration (pass) will<br>be presented by the DNS/ADNS at the facility's<br>monthly performance improvement committee<br>(Director of Nursing, Assist Director of Nursing,<br>Executive Director, Case Manager, Business<br>Office Manager, Admissions Coordinator,<br>Maintenance Supervisor, Account Manager,<br>Infection Control Nurse, Dietician, Medical<br>Director, Activities, and MDS Coordinator)<br>meeting for review and discussion with<br>recommendations if indicated. |  |   |
| F 223<br>SS=J  | 483.13(b), 483.13(c)(1)(i) FREE FROM<br>ABUSE/INVOLUNTARY SECLUSION<br><br>The resident has the right to be free from verbal,<br>sexual, physical, and mental abuse, corporal  | F 223   | F223<br>It is the practice of this facility to ensure each<br>resident is free from verbal, sexual, physical, and<br>mental abuse, corporal punishment and<br>involuntary seclusion.   |  | 8/3/2012  |

*Sylvia J. Bustin RN, NHA*

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| F 223  | <p>Continued From page 5<br/>punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on medical record review, facility policy review, observation, review of facility investigation, Ambulance Service Complete Report, and interview, the facility failed to protect one resident from abuse (#11) transported by emergency personnel from the facility to the emergency room of forty residents reviewed.</p> <p>The facility's failure placed resident #11, in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death).</p> <p>The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy on July 11, 2012, at 2:12 p.m., in the Administrator's Office.</p> <p>The Immediate Jeopardy constitutes Substandard Quality of Care and was effective July 10, 2012, through July 11, 2012. An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions validated on-site by the survey team on July 12, 2012.</p> <p>The findings included:</p> |   |  | F 223  | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Nursing staff assessed resident #11 upon return from treatment in the emergency room for a head wound suffered in a fall the morning of the event, July 10, 2012. Social Services conducted follow-up psychosocial assessment on July 11, 2012 and on July 12, 2012 and noted no negative outcomes apparent with the identified resident. Care Plan reviewed with additional interventions added related to fall on July 10, 2012 no other changes indicated.</p> <p>Director of Nursing Services has reviewed event reports from the last 60 days and no other incidents of inappropriate behavior or allegations of abuse by non-staff has been neither reported nor noted in morning clinical rounds. On July 10, 2012 the facility Executive Director called the Assistant Director of Emergency</p> <p>Medical Services to report the surveyor's concerns that EMS staff had been rude towards the resident #11. The Assistant Director of Emergency Medical Services and the State Regional Director responded by coming to the Facility and discussing the event with the surveyor. The Facility Executive Director submitted a written request to the Assistant Director of Emergency Medical Services that EMS #1 and EMS #2 not be scheduled to perform any transport of facility residents until an investigation was completed and corrective action implemented. The Assistant Director of Emergency Medical Services is requiring EMS #1 and EMS #2 complete an in-service program on</p> |   |                            |

*Sylvia J. Burton R.N., NHA*

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| F 223  | <p>Continued From page 6</p> <p>Resident #11 was admitted to the facility on June 14, 2010, with diagnoses of Alzheimer's Dementia, Depression, Agitation, and Behavioral Disturbances.</p> <p>Medical record review of the Minimum Data Set (MDS) dated April 30, 2012, (quarterly assessment), revealed the resident had short and long term memory problems, was severely impaired for daily decision making, and had physical behaviors toward others occurring four to six days but less than daily.</p> <p>Medical record review of the Care Plan initiated May 2, 2012, revealed, "...combative, hits, grabs staff, easily upset, behaviors sometimes present sometimes not...monitor for hitting, scratching and verbal aggression..."</p> <p>Review of the facility's Abuse Policy dated May 15, 2003, revealed, "Compliance Guidelines...Prohibitions on abuse apply to facility staff, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, and other individuals...Alleged Physical Abuse...Diffuse the situation, and remove the aggressor from all resident contact...if the resident could have an injury as a result of the alleged abuse, stabilize the resident's condition..."</p> <p>Observation on July 10, 2012, at 7:35 a.m., in the G-Hall dining room, revealed resident #11 lying on the floor and the facility staff providing first aid to a laceration to back of the head. Further observation at this time revealed the resident cooperating with staff.</p> | F 223   | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>how to handle patients with Dementia / Alzheimer's Disease by 7-25-2012. The clinical management staff (DNS/ADNS/SDC) will assist with training of Emergency Medical Services staff on dealing with the patient with dementia, on request and as needed. On July 10, 2012 the facility Executive Director notified the facility Medical Director, who is also Resident #11 attending physician, of the event and the surveyor's concerns. The facility Director of Nursing called the hospital emergency department to request the nurses examine the face, hands, and arms of Resident #11 for any signs of injury. The emergency room nurse reported none noted.</p> <p>On July 12<sup>th</sup>, the facility Executive Director notified the City Chief of Police of the incident and a report was completed. The facility Executive Director amended the contract with the County Emergency Medical Services to include a statement – "all Emergency Medical Services personnel will treat all of Facility's patients/residents with dignity and respect". The addendum was signed by the facility Executive Director and Assistant Director of Emergency Services on July 30, 2012.</p> <p>Each vendor/contractor signs a "Code of Conduct Summary" acknowledgement in which they acknowledge they will abide by all related federal and state laws/regulations and corporate policy and procedures such as resident rights, abuse prohibition, etc, while doing business with and /or in the Facility. The Assistant Director of Emergency Medical Services re-signed the "Code of Conduct Acknowledgement" on July 30, 2012.</p> |  |   |

Sylvia J. Burtin 7/30/12

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| F 223  | Continued From page 7<br><br>Observation on July 10, 2012, at 7:55 a.m., in the G-Hall, revealed the resident in a Geri-chair being wheeled down the hall and Certified Nurse Assistant #2 holding pressure to the laceration. Continued observation at this time revealed the resident cooperating with staff.<br><br>Observation on July 10, 2012, at 8:30 a.m., at the G-Wing Nurses Station, revealed resident #11 lying on the ambulance personnel's stretcher. Continued observation revealed ambulance personnel #1 spoke loudly to the resident stating, "stop, quit it, I will put a bag over your head." Continued observation revealed, ambulance personnel #2 stated, "and...(ambulance personnel #1)...will too." Continued observation revealed ambulance personnel #1 took an oxygen mask with tubing attached to a port on the mask approximately 2 centimeters in diameter (the tubing is usually attached to an oxygen tank in order to provide oxygen); removed the tubing by forcefully pulling at the tubing and placed the mask forcefully on the resident's face. Continued observation revealed the resident grabbed at the mask. Continued observation revealed ambulance personnel #1 slapped the resident's hands and ambulance personnel #2 grabbed the resident's hands, and placed the hands under the cloth strap on the stretcher. Continued observation revealed Licensed Practical Nurse (LPN) #3 did not intervene verbally or in any way after the oxygen mask (without being attached to oxygen source) was forcefully applied and the resident's hands were slapped by ambulance personnel #1. LPN #3 provided resident transfer paperwork to ambulance personnel #2 and both ambulance personnel rolled the stretcher down | F 223   | <i>This Plan of Correction is the center's credible allegation of compliance.</i><br><br><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i><br><br>On July 11, 2012 the Facility's policies and procedures for abuse and neglect prevention were reviewed and an addendum/ revision included to clarify the term visitors to encompass those of a professional nature to include but not limited to EMTs, paramedics, radiological technicians, laboratory technicians, physician, clergy, legal representatives.<br>District Director of Clinical Operations conducted in-service training with facility/contract management staff on July 11, 2012 on the Facility abuse policy and procedure clarification on the term visitors include all persons entering the facility to see/visit a resident includes those of a professional nature. Facility and contract managers began in-services with their staff beginning on the afternoon of July 11, 2012 and continuing as staff reported for duty the evening of July 11, 2012, the morning, afternoon and evening of July 12, 2012. Any staff/contract<br><br>employee who has not received the in-service training by close of business on July 12, 2012 i.e. employees on vacation, LOA, PRN staff, will receive the in-service on their next schedule day prior to assuming their duties on the floor. As of July 11, 2012 all newly hired staff when they receive their abuse training will include the revised/addendum policy & procedure information. Additional in-services to reinforce the facilities abuse policy and procedure were conducted on 7/19/12, 7/20/12, 7/21/12, 7/22/12, 7/23/12, 7/24/12 and 7/25/12. |                            |   |

Sylvia J. Burton RN, WHA

7/30/12

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| F 223  | <p>Continued From page 8<br/>the hall toward the exit.</p> <p>Observation on July 10, 2012, at 8:32 a.m., at the G-Hall exit door, revealed the resident on a gurney with both ambulance personnel with the resident. Interview with ambulance personnel #1 confirmed ambulance personnel #1 had been aware of the resident's diagnoses of Alzheimer's Dementia and stated, "That does not mean...does not understand and I'm still not going to be spit on." Continued observation revealed resident #11 was removed from the facility by ambulance personnel #1 and #2 without any facility staff intervention.</p> <p>Observation on July 10, 2012, at 8:35 a.m., in the G-Wing Nurses Station, revealed LPN #3 on the telephone and stated after hanging up the telephone, "I have to go tell my Director of Nurses what just happened."</p> <p>Review of the facility investigation dated July 10, 2012, hand written by LPN #3, revealed, "... (ambulance personnel #1)...stated to resident "what did I tell you about that you spit and I will cover your face up."...(LPN #3)...explained to...(ambulance personnel #2)...that resident had Alzheimer's Dementia et (and) that...(resident)...spits a lot...(ambulance personnel #2)...then said to...(LPN #3)..."I don't care what...(resident)...has...(resident)...is not and will not be spitting on us" as...(ambulance personnel #1)...was working with pt (patient) trying to put oxygen mask on resident, resident was resisting not wanting face mask on face et...(ambulance personnel #1)...slapped et grabbed at residents hand et pushed face mask down on residents face et said if...(resident)...kept on...(ambulance</p> | F 223   | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Facility Performance Improvement Committee (Director of Nursing, Assist Director of Nursing, Executive Director, Case Manager, Business Office Manager, Admissions Coordinator, Maintenance Supervisor, Account Manager, Infection Control Nurse, Dietician, Medical Director, Activities, and MDS Coordinator) verbally approved the addendum to the Facility's abuse policy at the in-service conducted with management staff on July 11, 2012.</p> <p>The Committee will meet on Friday July 13, 2012 to review status of in-service education and plan for full participation and expected date of full completion.</p> <p>The DNS/ADNS during weekday morning clinical rounds when reviewing event reports and 24 hour nursing reports will monitor for any evidence/documentation of inappropriate behavior by non-staff to ensure all appropriate actions per Facility's revised abuse policy and procedures had been reported and followed.</p> <p>The Committee will meet weekly on this issue to review status until 100% completion achieved.</p> <p>The DNS will continues present to the Facility Performance Improvement Committee any/all investigations of allegations of abuse that includes a review of compliance with the facility's P&amp;P on Abuse Prevention &amp; Investigation for review, discussion and recommendations, if indicated</p> |                            |   |

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| F 223  | <p>Continued From page 9</p> <p>personnel #1)...would cover...(resident)...head up...(LPN #3)...then explained again that... (resident)...was not oriented that...(resident)...was very confused...(LPN #3)...was picking up phone to call supervisor ambulance service was rolling resident via (by way of) gurney.</p> <p>Review of the facility investigation dated July 10, 2012, hand written by Rehabilitation Technician #1, revealed, "... (Rehabilitation Technician #1)...was in the speech office and over heard a male voice state "don't spit, I will put a bag over your head if you spit on me" immediately came out of office to see what was going on...saw a nurse at the desk and the ambulance service with a patient on the stretcher. One of the ambulance attendants was a male so...(Rehabilitation Technician #1)...assumed...(ambulance personnel #1)...was the one who said that. Patient was with nursing so...(Rehabilitation Technician #1)...went and notified my supervisor of the incident..."</p> <p>Review of the Medical Necessity Information (provided to ambulance personnel at time of transportation) dated July 10, 2012, revealed "...decreased mental status, Alzheimer's Disease..."</p> <p>Review of the Ambulance Service Complete Report dated July 10, 2012, revealed, "... Dispatch Priority: Urgent...Response Mode To Scene: No Lights or Sirens...Arrived at Scene: 7-10-2012 8:18...Arrived Patient: 7-10-2012 8:20...Transferred: 7-10-2012 8:30...Left Scene: 7-10-2012 8:32...Arrived Dest: 7-10-2012 8:44...Airway Breathing Condition: patent Respiration: normal...Mental status: alert, confused...altered mental status normal for this</p> | F 223   |  |                            |   |

*Elycia J. Buxton, RN, NHA*

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| F 223  | <p>Continued From page 10</p> <p>patient...7/10/2012 8:31...Protective Equipment Used: (not Applicable)...Suspected Contact With Body Fluids: (none listed)...Past Medical History:...Alzheimer's Disease, Dementia...Present History:...Staff states PT (patient) has HX (history) of being combative and spits, bites and hits...transported no lights or sirens..."</p> <p>Review of facility investigation dated July 10, 2012, hand written by the Administrator, revealed, "...Head of Ambulance Service notified came to facility took complete report of what happened..."</p> <p>Review of the facility investigation dated July 10, 2012, at 10:15 a.m., hand written by the Administrator, revealed, "...called...(Assistant Ambulance Director)...came...stated he would go back do...(Assistant Ambulance Director)...investigation and call...(Administrator)...back..."</p> <p>Review of the facility investigation dated July 10, 2012, at 2:50 p.m., hand written by the Administrator, revealed, "... (Assistant Ambulance Director)...called stated he had given employee involved in the incident with pt (patient) on G-Wing some thinking time. Then...(Assistant Ambulance Director)...would call... (employee)...back in and go from there..."</p> <p>Interview with the Director of Nursing (DON) on July 11, 2012, at 8:45 a.m., in the DON Office, confirmed if the ambulance personnel had been a facility employee the employee would have been removed from the situation immediately and the DON stated would expect the nurse who witnessed the alleged abuse to intervene,</p> | F 223   |  |  |  |   |  |

*Sylvia J. Burton RN, NHA*

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| F 223  | <p>Continued From page 11<br/>separate, and notify the DON or Administrator.</p> <p>Interview with the Rehabilitation Technician #1 on July 11, 2012, at 9:23 a.m., in the Speech Office, confirmed the Technician was in the Speech Therapy Office, with the door closed, (approximately fifteen feet from the nurses station), and heard a male state loudly on July 10, 2012, at approximately 9:20 a.m., "don't spit on me, I'll put a bag on your head", then opened the office door and witnessed the ambulance personnel #1 and LPN #3 with the resident; and reported the situation to the Rehab Supervisor. Continued Interview at this time revealed Rehabilitation Technician #1 witnessed the ambulance personnel #1 at the facility exit and heard ambulance personnel #1 state, "I don't care about the diagnosis I'm not going to be spit on."</p> <p>Interview with the Rehabilitation Supervisor on July 11, 2012, at 9:35 a.m., in the Speech Office, confirmed on July 10, 2012, Rehabilitation Technician #1 reported the ambulance personnel #1 loudly stated to resident #11, "don't spit on me, I'll put a bag on your head." Further interview with the Rehabilitation Supervisor confirmed the employees receive abuse training on hire, annually, as needed and are instructed to make sure the resident is safe, stop the abuse, remove the resident from the situation, and report to a supervisor immediately.</p> <p>Interview with the Staff Development Director (responsible for staff abuse in-services) on July 11, 2012, at 9:40 a.m., in the staff development office, confirmed the employees are instructed to separate the resident from the aggressor, and maintain safety when abuse is witnessed.</p> | F 223  |  |                            |  |

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| F 223  | <p>Continued From page 12</p> <p>Interview with the G-Hall Unit Manager on July 11, 2012, at 9:49 a.m., in the staff development office, confirmed the staff had been instructed to get the resident to safety, get the residents out of the situation, and report the abusive situation to someone with authority.</p> <p>Interview with the Administrator on July 11, 2012, at 10:30 a.m., in the Administrator's Office, confirmed the staff had been instructed during in-services on abuse to always get the resident to safety, stay with the resident, and report the situation to a supervisor immediately.</p> <p>Interview with LPN #3 on July 11, 2012, at 9:09 a.m., in the DON Office, confirmed during the facility's abuse training, instructions had been given to remove the resident from immediate danger and stop the abuse. Continued interview with LPN #3 confirmed had the ambulance personnel been facility employees the resident would have been removed from the situation and the resident would not have been left unattended with the alleged abuser. LPN #3 stated, "unsure boundaries with ambulance personnel. I feel like it was inappropriate and verbal abuse, I feel the mask and pushing the residents hands were physical abuse, I was shocked."</p> <p>The Immediate Jeopardy was effective from July 10, 2012, through July 11, 2012, and was removed on July 12, 2012. An acceptable Allegation of Compliance, which removed the immediacy of the Jeopardy, was received and corrective actions were validated on-site by the survey team on July 12, 2012, through review of facility documents and staff interviews. The</p> | F 223   |  |  |   |

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| F 223  | <p>Continued From page 13</p> <p>survey team verified the allegation of compliance by:</p> <p>1) Verifying resident #11 had been assessed by nursing staff upon return from the emergency room; Social Service conducted a follow up psychosocial assessment on July 11, 2012, and July 12, 2012.</p> <p>2) Verifying no other incidents of inappropriate behavior or allegations of abuse by non-staff had been reported or noted since last survey.</p> <p>3) Verifying the revision to the facility's policy titled, Abuse Prohibition, with an effective date July 12, 2012, and the facility's addendum to the Abuse Prohibition policy, individualized the term visitor to clarify to staff all visitors both personal and professional in function, to include but not limited to: 1) emergency medical technicians; 2) paramedics; 3) radiological technicians; 4) laboratory technicians; 5) physicians; 6) nurse practitioners; 7) clergy; 8) attorneys; and 9) legal representatives.</p> <p>4) Verification by the survey team on July 12, 2012, ensured by interviews with multidisciplinary staff, and review of in-service logs confirmed the staff received information regarding the facility's Abuse Prohibition revision including the term visitor including but not limited to: 1) emergency medical technicians; 2) paramedics; 3) radiological technicians; 4) laboratory technicians; 5) physicians; 6) nurse practitioners; 7) clergy; 8) attorneys; and 9) legal representatives. Staff interviews confirmed sound knowledge of the facility's expectations regarding the term visitors, and to protect the resident from abuse.</p> | F 223   |  |                            |   |

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| F 223  | Continued From page 14   | F 223  | <i>This Plan of Correction is the center's credible allegation of compliance.</i>   | 8/3/2012             |  |
| F 226<br>SS=J  | <p>Non-Compliance continues at a "D" level for monitoring corrective actions through the facility's Quality Assurance/Performance Improvement. The facility is required to submit a Plan of Correction.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on medical record review, observation, review of facility investigation, facility policy review, Ambulance Service Complete Report, personnel files, and interview, the facility failed to prevent abuse for one resident (#11), failed to implement the facility Abuse Policy, and failed to check the abuse registry for one employee of five employee files reviewed.</p> <p>The facility's failure placed resident #11, in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death).</p> <p>The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy on July 11, 2012, at 2:12 p.m., in the Administrator's Office.</p> | F 226  | <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F226.<br/>The facility does have and has implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br/>Nursing staff assessed resident #11 upon return from treatment in the emergency room for a head wound suffered in a fall the morning of the event, July 10, 2012. Social Services conducted follow-up psychosocial assessment on July 11, 2012 and on July 12, 2011 and noted no negative outcomes apparent with the identified resident. Care Plan reviewed with additional interventions added related to fall on July 10, 2012 no other changes indicated.<br/>Director of Nursing Services has reviewed event reports from the last 60 days and no other incidents of inappropriate behavior or allegations of abuse by non-staff has been neither reported nor noted in morning clinical rounds.<br/>On July 10, 2012 the facility Executive Director called the Assistant Director of Emergency Medical Services to report the surveyor's concerns that EMS staff had been rude towards the resident #11. The Assistant Director of Emergency Medical Services and the State Regional Director responded by coming to the Facility and discussing the event with the surveyor. The Facility Executive Director submitted a written request to the Assistant Director of Emergency Medical Services that</p> |                      |  |

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| F 226  | <p>Continued From page 15</p> <p>The Immediate Jeopardy constitutes Substandard Quality of Care and was effective July 10, 2012, through July 11, 2012. An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions validated on-site by the survey team on July 12, 2012.</p> <p>The findings included:</p> <p>Resident #11 was admitted to the facility on June 14, 2010, with diagnoses of Alzheimer's Dementia, Depression, Agitation, and Behavioral Disturbances.</p> <p>Medical record review of the Minimum Data Set (MDS) dated April 30, 2012, (quarterly assessment), revealed the resident had short and long term memory problems, was severely impaired for daily decision making, and had physical behaviors toward others occurring four to six days but less than daily.</p> <p>Medical record review of the Care Plan initiated May 2, 2012, revealed, "...combative, hits, grabs staff, easily upset, behaviors sometimes present sometimes not...monitor for hitting, scratching and verbal aggression..."</p> <p>Review of the facility's Abuse Policy dated May 15, 2003, revealed, "Compliance Guidelines...Prohibitions on abuse apply to facility staff, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, and other individuals...Alleged Physical Abuse...Diffuse the situation, and remove the aggressor from all resident contact...if the resident could have an</p> | F 226  | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>EMS #1 and EMS #2 not be scheduled to perform any transport of facility residents until an investigation was completed and corrective action implemented. The Assistant Director of Emergency Medical Services is requiring EMS #1 and EMS #2 complete an in-service program on how to handle patients with Dementia / Alzheimer's Disease by _____. The clinical management staff (DNS/ADNS/SDC) will assist with training of Emergency Medical Services staff on dealing with the patient with dementia, on request and as needed. On July 10, 2012 the facility Executive Director notified the facility Medical Director, who is also Residents #11 attending physician, of the event and the surveyor's concerns. The facility Director of Nursing called the hospital emergency department to request the nurses examine face, hands, and arms of Resident #11 for any signs of injury. The emergency room nurse reported none noted.</p> <p>On July 12<sup>th</sup>, the facility Executive Director notified the City Chief of Police of the incident and a report was completed.</p> <p>The facility Executive Director amended the contract with the County Emergency Medical Services to include a statement – "all Emergency Medical Services personnel will treat all of Facility's patients/residents with dignity and respect". The addendum was signed by the facility Executive Director and Assistant Director of Emergency Services on July 30, 2012.</p> <p>Each vendor/contractor signs a "Code of Conduct Summary" acknowledgement in which they acknowledge they will abide by all related</p> |                      |  |

Sylvia J. Huston RN, NHA

7/30/12

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| F 226  | <p>Continued From page 16</p> <p>injury as a result of the alleged abuse, stabilize the resident's condition..."</p> <p>Observation on July 10, 2012, at 7:35 a.m., in the G-Hall dining room, revealed resident #11 lying on the floor and the facility staff providing first aid to a laceration to back of the head. Further observation at this time revealed the resident cooperating with staff.</p> <p>Observation on July 10, 2012, at 7:55 a.m., in the G-Hall, revealed the resident in a Geri-chair being wheeled down the hall and Certified Nurse Assistant #2 holding pressure to the laceration. Continued observation at this time revealed the resident cooperating with staff.</p> <p>Observation on July 10, 2012, at 8:30 a.m., at the G-Wing Nurses Station, revealed resident #11 lying on the ambulance personnel's stretcher. Continued observation revealed ambulance personnel #1 spoke loudly to the resident stating, "stop, quit it, I will put a bag over your head." Continued observation revealed, ambulance personnel #2 stated, "and...(ambulance personnel #1)...will too." Continued observation revealed ambulance personnel #1 took an oxygen mask with tubing attached to a port on the mask approximately 2 centimeters in diameter (the tubing is usually attached to an oxygen tank in order to provide oxygen); removed the tubing by forcefully pulling at the tubing and placed the mask forcefully on the resident's face. Continued observation revealed the resident grabbed at the mask. Continued observation revealed ambulance personnel #1 slapped the resident's hands and ambulance personnel #2 grabbed the resident's hands, and placed the hands under the</p> | F 226   | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>federal and state laws/regulations and corporate policy and procedures such as resident rights, abuse prohibition, etc, while doing business with and /or in the Facility. The Assistant Director of Emergency Medical Services re-signed the "Code of Conduct Acknowledgement" on July 30, 2012.</p> <p>On July 11, 2012 the Facility's policies and procedures for abuse and neglect prevention were reviewed and an addendum/ revision included to clarify the term visitors to encompass those of a professional nature to include but not limited to EMTs, paramedics, radiological technicians, laboratory technicians, physician, clergy, legal representatives.</p> <p>District Director of Clinical Operations conducted in-service training with facility/contract management staff on July 11, 2012 on the Facility abuse policy and procedure clarification on the term visitors include all persons entering the facility to see/visit a residents includes those of a professional nature. Facility and contract managers began in-services with their staff beginning on the afternoon of July 11, 2012 and continuing as staff reported for duty the evening of July 11, 2012, the morning, afternoon and evening of July 12, 2012. Any staff /contract employee who has not received the in-service training by close of business on July 12, 2012 i.e. employees on vacation, LOA, PRN staff, will receive the in-service on their next schedule day prior to assuming their duties on the floor. As of July 11, 2012 all newly hired staff when they receive their abuse training will include the revised/addendum policy &amp; procedure information. Additional in-services to reinforce</p> |                            |   |

Sylvia J. Buxton RN, NHA

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| F 226  | <p>Continued From page 17</p> <p>cloth strap on the stretcher. Continued observation revealed Licensed Practical Nurse (LPN) #3 did not intervene verbally or in any way after the oxygen mask (without being attached to oxygen source) was forcefully applied and the resident's hands were slapped by ambulance personnel #1. LPN #3 provided resident transfer paperwork to ambulance personnel #2 and both ambulance personnel rolled the stretcher down the hall toward the exit.</p> <p>Observation on July 10, 2012, at 8:32 a.m., at the G-Hall exit door, revealed the resident on a gurney with both ambulance personnel with the resident. Interview with ambulance personnel #1 confirmed ambulance personnel #1 had been aware of the resident's diagnoses of Alzheimer's Dementia and stated, "That does not mean...does not understand and I'm still not going to be spit on." Continued observation revealed resident #11 was removed from the facility by ambulance personnel #1 and #2 without any facility staff intervention.</p> <p>Observation on July 10, 2012, at 8:35 a.m., in the G-Wing Nurses Station, revealed LPN #3 on the telephone and stated after hanging up the telephone, "I have to go tell my Director of Nurses what just happened."</p> <p>Review of the facility investigation dated July 10, 2012, hand written by LPN #3, revealed, "... (ambulance personnel #1)...stated to resident "what did I tell you about that you spit and I will cover your face up."...(LPN #3)...explained to... (ambulance personnel #2)...that resident had Alzheimer's Dementia et (and) that... (resident)...spits a lot...(ambulance personnel</p> | F 226   | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>the facilities' abuse policy and procedure was conducted on 7/19/12, 7/20/12, 7/21/12, 7/22/12, 7/23/12, 7/24/12 and 7/25/12.</p> <p>Facility Performance Improvement Committee (Director of Nursing, Assist Director of Nursing, Executive Director, Case Manager, Business Office Manager, Admissions Coordinator, Maintenance Supervisor, Account Manager, Infection Control Nurse, Dietician, Medical Director, Activities, and MDS Coordinator) verbally approved the addendum to the Facility's abuse policy at the in-service conducted with management staff on July 11, 2012.</p> <p>The Committee will meet on Friday July 13, 2012 to review status of in-service education and plan for full participation and expected date of full completion.</p> <p>The DNS/ADNS during weekday morning clinical rounds when reviewing event reports and 24 hour nursing reports will monitor for any evidence/documentation of inappropriate behavior by non-staff to ensure all appropriate actions per Facility's revised abuse policy and procedures had been reported and followed.</p> <p>The Committee will meet weekly on this issue to review status until 100% completion achieved.</p> <p>The DNS will continue to present to the Facility Performance Improvement Committee any/all investigations of allegations of abuse that includes a review of compliance with the facility's P&amp;P on Abuse Prevention &amp; Investigation for review, discussion and recommendations, if indicated</p> <p>The Tennessee Abuse Registry check was</p> |                            |   |

*Sylvia J. Buerken RN, NHA*

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| F 226  | <p>Continued From page 18</p> <p>#2)...then said to...(LPN #3)..."I don't care what... (resident)...has...(resident)...is not and will not be spitting on us" as...(ambulance personnel #1)...was working with pt (patient) trying to put oxygen mask on resident, resident was resisting not wanting face mask on face et...(ambulance personnel #1)...slapped et grabbed at residents hand et pushed face mask down on residents face et said if...(resident)...kept on...(ambulance personnel #1)...would cover...(resident)...head up...(LPN #3)...then explained again that...(resident)...was not oriented that...(resident)...was very confused...(LPN #3)...was picking up phone to call supervisor ambulance service was rolling resident via (by way of) gurney.</p> <p>Review of the facility investigation dated July 10, 2012, hand written by Rehabilitation Technician #1, revealed, "... (Rehabilitation Technician #1)...was in the speech office and over heard a male voice state "don't spit, I will put a bag over your head if you spit on me" immediately came out of office to see what was going on...saw a nurse at the desk and the ambulance service with a patient on the stretcher. One of the ambulance attendants was a male so...(Rehabilitation Technician #1)...assumed...(ambulance personnel #1)...was the one who said that. Patient was with nursing so...(Rehabilitation Technician #1)...went and notified my supervisor of the incident..."</p> <p>Review of facility investigation dated July 10, 2012, hand written by the Administrator, revealed, "...Head of Ambulance Service notified came to facility took complete report of what happened..."</p> <p>Review of the facility investigation dated July 10, 2012, at 10:15 a.m., hand written by the</p> | F 226   | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>completed on CNA #1 on 7/12/12 and no negative findings were noted. All current employees Kroll backgrounds have been check for the TN abuse registry verification. The facility has implemented a spreadsheet to verify that when we receive the Kroll background check back before hiring the employee that we check off that Kroll did verify the TN abuse registry before we go forward with hiring the employee. The Payroll Benefit Coordinator will review new hire personnel files on or before the hire date to ensure the Tennessee Abuse Registry check and documentation are on file.</p> <p>The Business Office Manager will report compliance with Abuse Registry checks during the Facility's regular monthly Performance Improvement Committee meetings and discuss any issues and recommendations, if indicated.</p> |  |   |

Sylvia J. Burton R.N. NHA

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| F 226  | <p>Continued From page 19</p> <p>Administrator, revealed, "...called...(Assistant Ambulance Director)...came...stated he would go back do...(Assistant Ambulance Director)...investigation and call...(Administrator)...back..."</p> <p>Review of the facility investigation dated July 10, 2012, at 2:50 p.m., hand written by the Administrator, revealed, "... (Assistant Ambulance Director)...called stated he had given employee involved in the incident with pt (patient) on G-Wing some thinking time. Then...(Assistant Ambulance Director)...would call... (employee)...back in and go from there..."</p> <p>Review of the Medical Necessity Information (provided to ambulance personnel at time of transportation) dated July 10, 2012, revealed "...decreased mental status, Alzheimer's Disease..."</p> <p>Review of the Ambulance Service Complete Report dated July 10, 2012, revealed, "... Dispatch Priority: Urgent...Response Mode To Scene: No Lights or Sirens...Arrived at Scene: 7-10-2012 8:18...Arrived Patient: 7-10-2012 8:20...Transferred: 7-10-2012 8:30...Left Scene: 7-10-2012 8:32...Arrived Dest: 7-10-2012 8:44...Airway Breathing Condition: patent Respiration: normal...Mental status: alert, confused...altered mental status normal for this patient...7/10/2012 8:31...Protective Equipment Used: (not Applicable)...Suspected Contact With Body Fluids: (none listed)...Past Medical History:...Alzheimer's Disease, Dementia...Present History:...Staff states PT (patient) has HX (history) of being combative and spits, bites and hits...transported no lights or</p> | F 226   |  |                            |   |

*Sylvia J. Bustin* AD, RHA

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| F 226  | <p>Continued From page 20<br/>sirens..."</p> <p>Interview with the Director of Nursing (DON) on July 11, 2012, at 8:45 a.m., in the DON Office, confirmed if the ambulance personnel had been a facility employee the employee would have been removed from the situation immediately and the DON stated would expect the nurse who witnessed the alleged abuse to intervene, separate, and notify the DON or Administrator.</p> <p>Interview with the Rehabilitation Technician #1 on July 11, 2012, at 9:23 a.m., in the Speech Office, confirmed the Technician was in the Speech Therapy Office, with the door closed, (approximately fifteen feet from the nurses station), and heard a male state loudly on July 10, 2012, at approximately 9:20 a.m., "don't spit on me, I'll put a bag on your head", then opened the office door and witnessed the ambulance personnel #1 and LPN #3 with the resident; and reported the situation to the Rehab Supervisor. Continued interview at this time revealed Rehabilitation Technician #1 witnessed the ambulance personnel #1 at the facility exit and heard ambulance personnel #1 state, "I don't care about the diagnosis I'm not going to be spit on."</p> <p>Interview with the Rehabilitation Supervisor on July 11, 2012, at 9:35 a.m., in the Speech Office, confirmed on July 10, 2012, Rehabilitation Technician #1 reported the ambulance personnel #1 loudly stated to resident #11; "dont spit on me, I'll put a bag on your head." Further interview with the Rehabilitation Supervisor confirmed the employees receive abuse training on hire, annually, as needed and are instructed to make sure the resident is safe, stop the abuse, remove</p> | F 226   |  |                            |   |

Sylvia J. Guston RN, NHA

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| F 226  | <p>Continued From page 21</p> <p>the resident from the situation, and report to a supervisor immediately.</p> <p>Interview with the Staff Development Director (responsible for staff abuse in-services) on July 11, 2012, at 9:40 a.m., in the staff development office, confirmed the employees are instructed to separate the resident from the aggressor, and maintain safety when abuse is witnessed.</p> <p>Interview with the G-Hall Unit Manager on July 11, 2012, at 9:49 a.m., in the staff development office, confirmed the staff had been instructed to get the resident to safety, get the residents out of the situation, and report the abusive situation to someone with authority.</p> <p>Interview with the Administrator on July 11, 2012, at 10:30 a.m., in the Administrator's Office, confirmed the staff had been instructed during in-services on abuse to always get the resident to safety, stay with the resident, and report the situation to a supervisor immediately.</p> <p>Interview with LPN #3 on July 11, 2012, at 9:09 a.m., in the DON Office, confirmed during the facility's abuse training, instructions had been given to remove the resident from immediate danger and stop the abuse. Continued interview with LPN #3 confirmed had the ambulance personnel been facility employees the resident would have been removed from the situation and the resident would not have been left unattended with the alleged abuser. LPN #3 stated, "unsure boundaries with ambulance personnel. I feel like it was inappropriate and verbal abuse, I feel the mask and pushing the residents hands were physical abuse, I was shocked."</p> | F 226   |  |  |  |   |  |

*Sylvia J. Buxton RN, NHA*

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| F 226   | <p>Continued From page 22</p> <p>Review of Certified Nurse Assistant's (CNA) #1's employee file hired May 8, 2012, currently employed at the facility and providing resident care, revealed the Tennessee Abuse Registry had not been checked.</p> <p>Interview with the Business Office Manager on July 12, 2012, at 4:15 a.m., in the front office, confirmed the facility failed to check the Tennessee Abuse Registry for CNA #1.</p> <p>The Immediate Jeopardy was effective from July 10, 2012, through July 11, 2012, and was removed on July 12, 2012. An acceptable Allegation of Compliance, which removed the immediacy of the Jeopardy, was received and corrective actions were validated on-site by the survey team on July 12, 2012, through review of facility documents and staff interviews. The survey team verified the allegation of compliance by:</p> <ol style="list-style-type: none"> <li>1) Verifying resident #11 had been assessed by nursing staff upon return from the emergency room; Social Service conducted a follow up psychosocial assessment on July 11, 2012, and July 12, 2012.</li> <li>2) Verifying no other incidents of inappropriate behavior or allegations of abuse by non-staff had been reported or noted since last survey.</li> <li>3) Verifying the revision to the facility's policy titled, Abuse Prohibition, with an effective date July 12, 2012; and the facility's addendum to the Abuse Prohibition policy, individualized the term visitor to clarify to staff all visitors both personal</li> </ol> | F 226  |  |                            |  |

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| F 226  | Continued From page 23<br>and professional in function, to include but not limited to; 1) emergency medical technicians; 2) paramedics; 3) radiological technicians; 4) laboratory technicians; 5) physicians; 6) nurse practitioners; 7) clergy; 8) attorneys; and 9) legal representatives.<br><br>4) Verification by the survey team on July 12, 2012, ensured by interviews with multidisciplinary staff, and review of in-service logs confirmed the staff received information regarding the facility's Abuse Prohibition revision including the term visitor including but not limited to; 1) emergency medical technicians; 2) paramedics; 3) radiological technicians; 4) laboratory technicians; 5) physicians; 6) nurse practitioners; 7) clergy; 8) attorneys; and 9) legal representatives. Staff interviews confirmed sound knowledge of the facility's expectations regarding the term visitors, and to protect the resident from abuse.<br><br>Non-Compliance continues at a "D" level for monitoring corrective actions through the facility's Quality Assurance/Performance Improvement. The facility is required to submit a Plan of Correction.<br><br>Refer to F-223 - the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. | F 226   |   |                            |   |
| F 431<br>SS=D  | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an   | F 431   | <i>This Plan of Correction is the center's credible allegation of compliance.</i><br><br><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i><br><br>F 431<br>It is the practice of this facility to employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and | 8/3/2012                   |   |

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| F 431  | <p>Continued From page 24</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on medical record review, observation, and interview the facility failed to ensure expired intravenous (IV) solution and supplies were discarded in a timely manner, and ensure safe medication storage for one resident (#3) of forty resident's reviewed.</p> | F 431   | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>disposition of all controlled drugs in sufficient details to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Inspection of all medication rooms, treatment rooms and central supply area was completed on 7/13/12 by the DNS, ADNS and RN supervisors. No additional expired medications or medical/nursing supplies were located.</p> <p>To ensure that the deficient practice does not recur. In-service with licensed nurses on drug storage/medication rooms will completed by 7/25/12 by DNS/ADNS/SDC. In-services are scheduled for 7/19/12, 7/20/12, 7/21/12, 7/22/12, 7/23/12, 7/24/12 and 7/25/12.</p> <p>Charge nurses will routinely check the medication room storage areas on or about the last day of each month and remove any expired biologicals and/or medical supplies. The DNS/ADNS and/or RN supervisor will conduct spot audits of each medication room on the first work day of each month to ensure compliance. Pharmacy consult will also conduct spot audit of one medication room each monthly visit and include finding in his report to the DNS/ADNS.</p> <p>The results of the audits will be presented by the DNS/ADNS at the facility's monthly performance improvement committee meeting for review and discussion with recommendations if indicated.</p> <p>Resident # 3 was re-assessed for self administration of medication on 7/11/12. Resident has been evaluated and approved by the</p> |  |   |

*Dylvia J. Burton*  
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| F 431  | <p>Continued From page 25</p> <p>The findings included:</p> <p>Observation on July 12, 2012, at 8:25 a.m., of the skilled wing medication room with Licensed Practical Nurse (LPN) #1, revealed a 1000 ml (milliliter) bag of 10% (percent) Dextrose IV solution with an expiration date of April 2012.</p> <p>Interview on July 12, 2012, at 8:25 a.m., with LPN #1, in the skilled wing medication room confirmed the IV fluid had expired and should have been discarded.</p> <p>Observation on July 12, 2012, at 8:45 a.m., of the A/B wing medication room with LPN #2 revealed three, 20 gauge IV catheters with expiration dates of August 2010.</p> <p>Interview on July 12, 2012, at 8:45 a.m., with LPN #2 in the A/B medication room confirmed the IV supplies had expired and should have been discarded.</p> <p>Resident #3 was admitted to the facility on March 17, 2008, with diagnoses including Chronic Obstructive Pulmonary Disease, Fecal and Urine Incontinence, Deconditioning, Large Hiatal Hernia, and Grade I Diastolic Dysfunction.</p> <p>Medical record review of the quarterly Minimum Data Set (MDS) dated June 8, 2012, revealed the resident usually understands and is usually understood by others.</p> <p>Review of the Evaluation for Self-Administration of Medications assessment dated April 22, 2011, revealed the resident "...Can administer inhalant</p> | F 431  | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>interdisciplinary team to be capable of set-up and self administration of his/her breathing treatment. Resident agreed to let nurse keep medication in medication cart and ask for it when needed. Care plan has been updated accordingly.</p> <p>All residents with orders to self administer medications will be reviewed and re-assessed by DNS/nurse manager by 7/20/12. Re-assessment will determine continuation of self administration. Appropriated orders and assessment forms will be completed as needed and care planned.</p> <p>To ensure that the deficient practice does not recur, the licensed nurses will assess any resident who requests self administration of medication, complete assessment forms, and notify the Interdisciplinary Care Plan Team for review, approval, appropriate physician orders, secure in-room drug storage if indicated and care plan update. Order will be written on Medication Administration Record and the licensed nurse will monitor and document use of medication each shift as indicated.</p> <p>Charge nurse will document this information on the 24 hour report book in order for the DNS/ADNS to follow-up and report in clinical meeting each weekday morning.</p> <p>Each residents' continued ability to self administer any medication will be reviewed and documented by the Interdisciplinary Care Plan Team at least quarterly and with any significant change in resident's condition. The Care Plan / MDS Coordinator will maintain a current list of residents on self administration program and report on status along with any issues at the facility's monthly performance improvement</p> |                      |  |

*Sylvia J. Burton R.N., WHA*

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| F 431  | <p>Continued From page 26</p> <p>medications with proper procedure..." Continued review revealed the interdisciplinary team had approved the resident to self-administer inhalant medications on April 22, 2011.</p> <p>Review of the physician's recapitulation orders dated July 2012 revealed "...May self-administer nebulizer treatments after set up by nurse..."</p> <p>Review of the resident's care plan dated October 28, 2011, and revised with a goal date of September 5, 2012, revealed "... (resident name) may administer nebulizer treatments once set up and given to res (resident) by med (medication) nurse per self. Knows how to turn on and off and to return tubing...to bag after use..."</p> <p>Observation in the resident's room on July 10, 2012, at 9:40 a.m., revealed the resident got out of bed, took self to the bathroom, returned to the bedside, removed a plastic, single dose nebulizer ampule from the night stand beside the bed, broke the top off the ampule, and poured the medication in the receptacle on the nebulizer mask. Continued observation revealed the resident placed the mask over the mouth and nose, and secured the mask in place with the elastic strap behind the head. Continued observation revealed the resident turned on the aerosol machine, and a fine mist began coming from the nebulizer mask.</p> <p>Observation and interview with the Licensed Practical Nurse #4 on July 10, 2012, at 9:45 a.m., in the hallway outside the resident's room confirmed the resident had been assessed for self-administration after nurse set-up.</p> |   |  | F 431  | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>meeting for discussion and recommendations, as indicated.</p> |   |                            |

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| F 431  | Continued From page 27<br>Observation with LPN #4 at this time, revealed four single-dose medication ampules were found in the resident's nightstand. Interview with LPN #4 confirmed the medication should not have been stored in the resident's nightstand.   | F 431   | <i>This Plan of Correction is the center's credible allegation of compliance.</i>  |                            |   |
| F 441<br>SS=D  | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. | F 441   | <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i><br><br>F 441<br>It is the practice of this facility to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.<br>C.N.A. # 2 received counseling by the DNS on facilities policy on use of gloves on 7/20/12 and received additional retraining on infection prevention and glove use on 7/20/12.<br>In-service education with all nursing staff will be conducted by 7/26/12 on infection control and use of gloves by the DNS/, ADNS, and/or SDC. In-services are scheduled for 7/19/12, 7/20/12, 7/21/12, 7/22/12, 7/23/12, 7/24/12 and 7/25/12. The SDC will continue to include in nursing orientation Infection Prevention Practices including use of gloves.<br>DNS/ADNS/SDC and RN supervisors will make rounds 3-5 times a week on each shift to monitor and ensure nursing staff are using gloves in accordance with the facility's Infection Prevention policies. Nursing staff observed not following policy on use of gloves will have disciplinary action carried out by the DNS/ADNS/SDC or nursing managers.<br>These rounds by DNS/ADNS/ SDC and/or RN supervisors will continue weekly X 4 weeks or until substantial compliance achieved and then Infection Prevention rounds will be conducted monthly by the facility Infection Preventionist nurse.<br>Results of the weekly audits and monthly Infection Prevention rounds will be reported | 8/3/2012                   |   |

*Sepia Buston RN, NHA*

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| F 441  | <p>Continued From page 28</p> <p>(c) Linens<br/>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, facility policy review, and interview, the facility failed to follow the facility's infection control practices for use of appropriate personal protective equipment for one resident (#11) and cleaning the blood glucose monitor for one of five blood glucose monitors.</p> <p>The findings included:</p> <p>Observation in the G-Hallway on July 10, 2012, at 7:55 a.m., revealed Certified Nurse Assistant (CNA) #2 holding pressure with a gauze sponge to a resident's bleeding head laceration without the use of gloves.</p> <p>Review of facility policy, Work Practices: Personal Protective Equipment (PPE), revised April 28, 2010, revealed, "...gloves are worn when contact with blood..."</p> <p>Interview with CNA #2 on July 10, 2012, at the time of the observation, revealed gloves are to be worn when there is contact with blood and confirmed gloves were not worn when holding pressure to a bleeding laceration.</p> <p>Interview with the Director of Nursing (DON) on July 10, 2012, at 2:00 p.m., in the Administrator's Office, confirmed gloves are to be worn when</p> | F 441   | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>to the facility performance improvement committee (Director of Nursing, Assist Director of Nursing, Executive Director, Case Manager, Business Office Manager, Admissions Coordinator, Maintenance Supervisor, Account Manager, Infection Control Nurse, Dietician, Medical Director, Activities, and MDS Coordinator) by the Infection Preventionist nurse monthly for review, discussion and recommendations, if indicated.</p> <p>LPN # 3 has been counseled by the DNS on procedure when cleaning glucose machine between residents on 7/19/12. LPN # 3 verbalized understanding and return demonstration with the SDC on 7/19/12.</p> <p>In-service with all licensed nurses will be conducted by 7/26/12 with documentation of return demonstration. In-services are scheduled for 7/19/12, 7/20/12, 7/21/12, 7/22/12, 7/23/12, 7/24/12 and 7/25/12. The SDC will continue to include in nursing orientation Infection Prevention Practices including cleaning of glucometers.</p> <p>DNS/ADNS/SDC and RN supervisors will make rounds 3-5 times a week on each shift to monitor and ensure nursing staff are cleaning glucometers in accordance with the facility's Infection Prevention policies. Nursing staff observed not following policy on cleaning glucometers will have disciplinary action carried out by the DNS/ADNS/SDC or nursing managers.</p> <p>These rounds by DNS/ADNS/ SDC and/or RN</p> |  |   |

*Sylvia J. Bustin* 7/30/12  
RN, NAA

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| F 441  | Continued From page 29<br>contact with blood or body fluids and the facility<br>failed to follow the policy and procedure for PPE.<br><br>Observation in the G-Hallway on July 10, 2012, at<br>11:49 a.m., and 12:00 p.m., revealed Licensed<br>Practical Nurse (LPN) #3 cleaned the blood<br>glucose monitor wiping only the top of the<br>monitor. Continued observation revealed the test<br>strip holder that came in contact with the blood<br>had not been cleaned.<br><br>Review of facility policy, Sure Step Flexx Blood<br>Glucose Monitoring System Calibration and<br>Cleaning, revised October 31, 2010, revealed,<br>"...clean the outside of the meter...in-between<br>each resident..."<br><br>Interview on July 10, 2012, at 12:00 p.m., with<br>LPN #3, at the time of the observation, confirmed<br>the meter had not been cleaned per facility policy<br>and procedure.<br><br>Interview on July 10, 2012, at 2:00 p.m., with the<br>DON, in the Administrator's Office, confirmed the<br>outside of the blood glucose monitor was to be<br>cleaned with a 10% (percent) bleach solution<br>moistened wipes in-between each resident and<br>the facility had failed to follow policy and<br>procedure for cleaning the blood glucose monitor. | F 441   | <i>This Plan of Correction is the center's credible<br/>allegation of compliance.</i><br><br><i>Preparation and/or execution of this plan of correction<br/>does not constitute admission or agreement by the<br/>provider of the truth of the facts alleged or conclusions<br/>set forth in the statements of deficiencies. The plan of<br/>correction is prepared and/or executed solely because<br/>it is required by the provisions of federal and state law.</i><br><br>supervisors will continue weekly X 4 weeks or<br>until substantial compliance achieved and then<br>Infection Prevention rounds will/are conducted<br>monthly by the facility Infection Preventionist<br>nurse.<br>Results of the weekly audits and monthly<br>Infection Prevention rounds will be reported to<br>the facility performance improvement committee<br>by the Infection Preventionist nurse monthly for<br>review, discussion and recommendations, if<br>indicated. |                            |   |
| F 463<br>SS=D  | 483.70(f) RESIDENT CALL SYSTEM -<br>ROOMS/TOILET/BATH<br><br>The nurses' station must be equipped to receive<br>resident calls through a communication system<br>from resident rooms; and toilet and bathing<br>facilities.   | F 463   | P463<br>The facility's nurse stations are equipped to<br>receive resident call through a communication<br>system from resident rooms, and toilet and<br>bathing facilities.<br>The call light for Resident #252 was replaced<br>during the survey as soon as it was identified as<br>inoperative.  | 8/3/2012                   |   |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445136 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br>07/12/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED NURSING AND REHABILITATION-MASTERS |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>278 DRY VALLEY RD<br>ALGOOD, TN 38501   |                            |   |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE |   |
| F 463  | <p>Continued From page 30</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review, observation, and interview, the facility failed to ensure the call light was functioning for one resident (#252) of forty residents reviewed.</p> <p>The findings included:</p> <p>Resident #252 was admitted to the facility on June 12, 2012, with diagnoses including Hypertension, Congestive Heart Failure and Osteoarthritis.</p> <p>Observation on July 10, 2012, at 3:18 p.m., in the resident's room, revealed the call light did not function when a resident attempted to call for staff assistance.</p> <p>Interview with Certified Nursing Assistant (CNA #3), at the time of the observation, on July 10, 2012, confirmed the light did not function (no audible or visual alarm activated) and the call light needed to be replaced. Continued interview confirmed the resident was temporarily unable to call for staff assistance.</p> | F 463   | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>On 7/13/12 and 7/19/12 the maintenance staff made rounds throughout the facility and checked every call light in every location (pt rooms, bathrooms, showers, etc) and all were in working order.</p> <p>The Maintenance Supervisor maintains extra call light cords that are available at the nurses stations for replacement when a call light cord malfunctions. The staff then notes the replacement on the 24 hr report and the DNS/ADNS reviews on weekday clinical rounds review and reports in the management morning meeting at which the maintenance supervisor is present.</p> <p>The facility call light system is included in the facility Maintenance Dept Preventative Maintenance Program and all call lights and the system are checked monthly and logged.</p> <p>The Maintenance Supervisor includes operation &amp; checks of the call light system in his report in the monthly Safety Committee and Performance Improvement Committee (Director of Nursing, Assist Director of Nursing, Executive Director, Case Manager, Business Office Manager, Admissions Coordinator, Maintenance Supervisor, Account Manager, Infection Control Nurse, Dietician, Medical Director, Activities, and MDS Coordinator) meeting for review, discussion and recommendations, if indicated</p> |                            |   |

*Sylvia J. Bustin RN, NHA*

*7/30/12*